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percentage for all public disproportionate share hospitals prior to multiplication of that percentage b the inflated hospital-specific base year 1991 operating costs. In the event a

reduction to this 40% payment adjustment is necessary, such a reduction would be proportional based on estimated Medicaid inpatient admissions.

- Sum the percentage derived from the steps above to determine the payment adjustment percentage.

(2) Multiply the payment adjustment percentage by the inflated hospital-specific base year 1991 operating costs for each DSH.

(3) Calculate bad debt and uncompensated services costs by multiplying these total hospital costs by the percentage of Medicaid patient days for each DSH.

(4) Add inflated operating costs and costs of uncompensated services and bad debts and divide by the 1991 discharges to obtain the payment adjustment amount per case for each DSH.

(5) Reduce the payment adjustment amount per case for nonpublic hospitals by 50%.

(6) Multiply the payment adjustment amount per case by the estimated number of admissions for each DSH. The product is the estimated DSH payment adjustment. The payment adjustment amount per case is subject to adjustment by the Department. Such an adjustment would be a proportional reduction based on Medicaid admissions or Medicaid base year inpatient costs.

Public hospitals are limited, by Federal mandate, to a calculated disproportionate share payment cap for the 1995 state fiscal year equal to uncompensated medical care costs. The hospital-specific DSH cap is defined by the following formula:

DSH Cap = Medicaid costs + Costs of services to uninsured patients - non-DSH payments.

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Should a public hospital's DSH payments exceed the hospital-specific DSH limit, the DSH intensity allowance will be reduced, causing the per case rate to decrease. The difference between the original rate and the revised rate will be multiplied by the number of paid admissions for the period to determine the amount of the overpayment. If necessary, other DSH payments will be adjusted or suspended. Public hospitals that qualify as a "high disproportionate share" hospital in accordance with Section 1923 (g)(2)(B) of the Social Security Act may exceed the hospital-specific DSH cap by up to 200%, in state fiscal year 1995 only, if the State certifies that the monies above the cap are used for health services. Such excess payments will be made as DSH payments through the Indigent Care Trust Fund.

For each federal fiscal year, the HCFA places a limit on the aggregate DSH payments that the Department may make. If the Department's estimates indicate that the aggregate limit will be exceeded, the Department will reduce DSH payments to ensure that the limit is not exceeded.

The Department will make a payment adjustment effective for dates of admission July 1, 1995, and after, to disproportionate share hospitals which agree to comply with Department Rule 350-6-.03(3) See Appendix A. No less than 15% of the payment adjustment will be used for support of primary care services. The payment adjustment will be calculated November 1, 1995, for the period of July 1, through October 31; on or around November 30, for the month of November; and on or around December 31 for the month of December.

(1) Calculate a payment adjustment percentage for each DSH provider using the steps below.

- Add 50% for each DSH provider.
- Add 0-50% proportionally for DSH providers whose percentage of Medicaid days is greater than the statewide mean percentage of Medicaid days.
- Add 12.5% for each additional DSH criterion that a hospital meets.
- Add 0-50% proportionally based on the percentage

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of Medicaid births to total births for each hospital.

- Add 25% if the hospital is the only Medicaid-enrolled hospital in its county.

- Add 0-100% proportionally for hospitals with calendar year 1993 admissions greater than 1000.

- Add no more than 40% to the payment adjustment percentage for all public disproportionate share hospitals prior to multiplication of that percentage by the inflated hospital-specific base year 1992 operating costs. In the event a reduction to this 40% payment adjustment is necessary, such a reduction would be proportional based on estimated Medicaid inpatient admissions.

- Sum the percentage derived from the steps above to determine the payment adjustment percentage.

(2) Multiply the payment adjustment percentage by the inflated hospital-specific base year 1992 operating costs for each DSH.

(3) Calculate bad debt and uncompensated services costs by multiplying these total hospital costs by the percentage of Medicaid patient days for each DSH.

(4) Add inflated operating costs and costs of uncompensated services and bad debts and divide by the 1992 discharges to obtain the payment adjustment amount per case for each DSH.

(5) Reduce the payment adjustment amount per case for nonpublic hospitals by 50%.

(6) Multiply the payment adjustment amount per case by the estimated number of admissions for each DSH. The product is the estimated DSH payment adjustment. The payment adjustment amount per case is subject to adjustment by the Department. Such an adjustment would be a proportional reduction based on Medicaid admissions or Medicaid base year inpatient costs.

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Effective with DSH payments made on and after July 1, 1995, all DSH providers are subject to a hospital-specific DSH limit. The limit is defined as outlined below.

(Costs of Medicaid services LESS Medicaid non-DSH payments.) PLUS (Costs of services to individuals with no insurance or other third party coverage LESS payments received from individuals with no insurance or other third-party coverage.)

Subject to the availability of funds, the Department will make a payment adjustment to disproportionate share hospitals which agree to comply with Department Rule 350-6-.03(3). See Appedix A. The payment adjustments will be calculated as outlined below and will be made on or about November 1, 1996, and before December 31, 1996. In the event that guidelines regarding the availability of federal funds used in this program should be subject to change, to better assure that the Department will not expend funds for which federal matching funds are not available, the Department may extend the ending date for making Indigent Care Trust Fund adjustment payments to a date sixty days after federal guidelines are finalized or June 30, 1997, whichever occurs earlier.

(1) Calculate a payment adjustment percentage for each DSH provider using the steps below.

- Add 50% for each DSH provider.
- Add 0-50% proportionally for DSH providers whose percentage of Medicaid days is greater than the statewide mean percentage of Medicaid days.
- Add 12.5% for each additional DSH criterion that a hospital meets.
- Add 0-50% proportionally based on the percentage of Medicaid births to total births for each hospital.
- Add 25% if the hospital is the only Medicaid-enrolled hospital in its county.

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- Add 0-100% proportionally for hospitals with calendar year 1994 admissions greater than 1000.

- Add no more than 100% to the payment adjustment percentage for all public disproportionate share hospitals prior to multiplication of that percentage by the inflated hospital-specific base year 1993 operating costs.

- Sum the percentage derived from the steps above to determine the payment adjustment percentage.

(2) Multiply the payment adjustment percentage by the inflated hospital-specific base year 1993 operating costs for each DSH.

(3) Calculate bad debt and uncompensated services costs by multiplying these total hospital costs by the percentage of Medicaid patient days for each DSH.

(4) Add inflated operating costs, costs of uncompensated services, and bad debts and divide by the 1993 discharges to obtain the payment adjustment amount per case for each DSH.

(5) Reduce the payment adjustment amount per case for non-public hospitals by 60%.

(6) Multiply the payment adjustment amount per case by the estimated number of admissions for each DSH. The product is the estimated DSH payment adjustment. The payment adjustments amount per case is subject to adjustment by the Department.

5/15/97 Subject to the availability of funds, the Department will adjust payments to public hospitals with less than 100 beds located in a non-MSA with an inpatient Medicaid utilization of at least 1% which agree to comply with Department Rule 350-6-.03(3).

The payment adjustment will be calculated as outlined below:

(a) Calculate the Medicaid shortfall.
(b) Calculate the costs of rendering services to individuals with no insurance or other third

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party payer.

(c) Determine Medicaid admissions for each hospital's base fiscal year.

(d) Calculate base year cost per admission by adding (a) and (b) and dividing by (c) above.

(e) Multiply base year cost per admission by estimated Medicaid admissions for the current federal fiscal year.

All DSH providers are subject to the hospital-specific DSH limit and the aggregate statewide DSH limit defined above in Section G of this State Plan.

H. Reviews and Appeals

In general, providers may submit written inquiries concerning the rate determination process or requests for review of their specific rates. Only the following will be considered under the procedures herein described:

- Evidence that the audited cost report figures used to determine the base rate contained an error on the part of the Department or its agents.
- Evidence that the Department made an error in calculating the prospective rate of payment.
- Evidence that the Department is not complying with its stated policies in determining the base rates, trend factor, or utilization constraints.
- Hospitals may appeal for a rate adjustment if they have significant changes in patient care services which resulted in an increase in costs since the base year. The Department will require proof of these increased patient costs, and documentation of the increase in case-mix intensity of Medicaid cases.

Prospective Per Case Rate Appeals

1. Information concerning the base rate and prospective rate will be provided to each hospital prior to the effective date. A hospital will have 30 days from the date on the correspondence to submit a request

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for adjustment concerning the rate determination process. If no adjustment request is submitted within this time period, a hospital may not contest its rate of payment. There is no time limitation for the Department to reduce a hospital's rate when an error is discovered.

2. Written requests must be submitted to the Coordinator of the Hospital Reimbursement Unit. Requests for review must include evidence on which the request is being based. Hospitals which do not submit written request or inquiries within thirty days of the date of such information will be considered to have accepted their rates as received. Similarly, failure of the hospital to state the basis for review and to include relevant supporting evidence for the Department's consideration, when requesting an Administrative Review, will also result in a denial of further appeal rights on the rate of payment. The Coordinator of Hospital Reimbursement will have sixty (60) days from the date of receipt to render a decision concerning the written requests or inquiries submitted by a hospital if no additional information is required. The Coordinator may have more than sixty (60) days to render a decision if additional information is requested. If the Coordinator of Hospital Reimbursement requests additional information, the request must be issued within thirty (30) days of receipt, and the hospital must respond within thirty (30) days of receipt of such request. The Coordinator of Hospital Reimbursement will have thirty (30) days from the receipt of the additional information to render a decision in writing. The failure of the Coordinator of Hospital Reimbursement to render a decision within the above-stated time frame will result in a decision in favor of the hospital concerning the issue raised by the hospital on appeal.

3. Failure of a hospital to provide information within the specified time frame as requested by the Coordinator of Hospital Reimbursement will result in the denial of the hospital's appeal by the Coordinator of Hospital Reimbursement. A hospital which disagrees with the determination of the

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Coordinator of Hospital reimbursement may request a hearing. If the request is not received by the Office of Legal Services within ten (10) days of the date of the Coordinator's decision, the hospital will be deemed to have waived any and all further appeal rights.

I. Adjustments to Rates

The effect of any CON approved capital improvement on depreciation expense for buildings and fixed equipment or changes in cost for services of hospital-based physicians occurring from November 16 through May 15 (inclusive) of any year, will be recognized in a rate change effective the following July 1. Changes occurring from May 16 through November 15 (inclusive) will be effective January 1 of the subsequent year. Costs associated with a revaluation of assets as a result of the sale or lease of a facility which occurred after November 8, 1983, will not be considered for the purpose of determining or adjusting a hospital's rate of payment.

Effective with the establishment of per case rates on and after, July 1, 1991, costs for services of hospital-based physicians (HBP) will no longer be reimbursed by the Hospital program. HBP services must be billed to the Physicians program in order to obtain reimbursement.

VI. Payment Assurance

The State will pay each hospital for services provided in accordance with the requirements of the Georgia Title XIX State Plan and applicable State and Federal rules and regulations. The payment amount shall be determined for each hospital according to the standards and methods set forth in the Georgia Title XIX inpatient Hospital Reimbursement Plan.

Hospitals will continue to submit claims as they have in the past. All requirements for documented services and charges will remain in effect, and all screens for completeness will continue. Hospital claims will be subject to post-payment review. The Department will be requesting information from the hospitals to substantiate the necessity and appropriateness of services rendered. Any denials for lack of medical necessity, documentation, or other reasons will result in recoupment of monies paid to the provider. A reduced rate

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for less than acute care is not applicable nor required.

Unlike a per diem or percent or charges system, this reimbursement plan does not provide incentives for prolonging a patient's stay. If a patient remains in the hospital beyond the time of the medical necessity, the effect is to reduce the daily reimbursement rate.

VII. Provider Participation

This plan is designed to assure adequate participation of hospitals in the Medicaid Program, the availability of hospital services of high quality to recipients, and services within which are comparable to those available to the general public.

VIII. Revisions

The plan will be revised as operating experience data are developed and need for changes is necessary in accordance with Federal and State regulations. If it is found that there are insufficient controls on utilization transfers or cost, or if the Department determines that a different reimbursement methodology is warranted, the Department maintains its right to discontinue this system upon appropriate public notice of the proposed change.

IX. Payment In Full

A. Participating in-state providers must accept the amount paid in accordance with the Georgia Title XIX Inpatient Hospital Reimbursement Plan as payment in full for covered services.

B. Settlement

For admissions occurring each calendar year, a comparison of a hospital's total Medicaid payments and its total charges will be made for claims paid on or before September 30 of the following year. A refund will be due from the hospital for any amount by which total Medicaid payments are in excess of a hospital's total charges for Medicaid patients.

For enrolled non-Georgia hospitals, the comparison will

be made beginning with payments and charges for admissions occurring during the calendar year 1990 and after.

Total Medicaid payments included in the comparison shall not include payment adjustments made to Georgia or non-Georgia enrolled disproportionate share hospitals. There

will be no other cash settlement except as outlined in Subsection 1001.3 of the Hospital manual. Total payments will include the appropriate inpatient hospital co-payments.

The Department will review hospital cost reports to verify several rate components. The reimbursement methodology assumes that services in the base year will continue and, therefore, audited cost reports will be reviewed to determine that all services and facilities included in the base year will continue in the reimbursement year on the basis of biannual surveys from the hospital. Additionally, all surveyed items including physician reimbursement will be subject to verification.

An amended audited cost report will not be recognized for the purpose of adjusting reimbursable costs (inpatient and outpatient) if the amended report is received more than three (3) years after the initial audit of the cost report is completed. (For definition purposes, this date is established as the date of initial notification for audit completion to the provider.)

X. Reimbursement for Cost Outlier Cases (Enrolled Hospitals)

A hospital which has an unusually costly admission (or admissions) during the reimbursement year may obtain additional reimbursement for the admission under circumstances described below. This additional reimbursement, determined on a case-by-case basis, may be granted if the cost of the admission in question exceeds the threshold established for the hospital.

To obtain additional reimbursement for an unusually expensive admission (outlier), a hospital must make a request to the Coordinator or the Hospital Reimbursement Unit and provide the following information: